Variables for Predicting Successful Completion of a Treatment Program for Juvenile Males Who Have Committed Sex Offenses

Thesis

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Abstract

According to the most recent data from the U.S. Department of Justice (2007), adolescents (all genders) perpetrate about 22% of all sex offenses and 15% of all rapes. The importance of rehabilitation in these formative years is significant, especially considering that about half of adults who committed sex offenses have disclosed that their first offenses were committed during adolescence (Fritz, 2003). The purpose of this research was to ask, "Which variables can best predict successful completion of a residential treatment program for juvenile males who have committed sex offenses?" The data used in this study were collected at Hittle House, a residential treatment facility in Columbus specializing in programming for adolescent males who have been identified as being "sexually reactive". Included was information from record review for all 94 discharged cases for the categorical variables of victim type (sibling, friend, or stranger), adoption/foster care history (yes or no), and levels of parental/guardian involvement (low, moderate, high), as well as the continuous variable of Juvenile Sex Offender Assessment Protocol (J-SOAP) scores. Logistic regression analysis for the J-SOAP scores predicted successful program completion versus other outcomes 67% of the time, where lower problem scores were associated with successful completion ($p<.001$). Chi-square analysis was significant for successful outcome by parent involvement ($p<.05$), but not by victim type or adoption history; parent involvement was not significantly related to victim type, but was related to adoption/foster care history ($p<.05$). Analysis of variance showed parental involvement was lowest when J-SOAP problem scores were high ($p<.05$) and J-SOAP scores were unrelated to victim type. With these results, this

study offers insight for clinicians at Hittle House and other similar programs, as well as a starting point for further and deeper analyses.

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Curriculum Vitae

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Fields of Study

Major Field: Social Work

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Chapter 1: Statement of Research Topic

According to the U.S. Department of Justice (2007), adolescents (all genders) perpetrated approximately 22% of all sex offenses and 15% of all rapes. About 50% of adults who have committed sex offenses have disclosed that their first offenses were actually committed while they were juveniles between the ages of 8 and 18 (Abel, Mittelman, & Becker, 1985; Fritz, 2003). The importance of rehabilitation in these formative years is significant, especially considering that those who reoffend in adulthood do so at higher rates in the offense categories of rape, child molestation, and exhibitionism (Marshall & Barbaree, 1990).

There are many studies which examine risk factors of recidivism among juveniles who have perpetrated sex offenses, and current evidence appears to support the efficacy of diversion programs in reducing recidivism of this population. About one-quarter of juveniles who are processed through the juvenile court system are referred to a diversion program for rehabilitation (Puzzanchera & Kang, 2008). Higher rates of recidivism have been associated with a deeper trajectory into the more punitive juvenile justice practices, such as incarceration, and the associated exposure to antisocial attitudes (Lundman, McAra, & McVie, 2007).

Treatment is important because it helps those who have committed offenses identify the etiology of their problematic sexual behaviors. Once they identify their own cognitive distortions, they work with therapists to change their thought processes to cease offending behaviors. It is very common to see juveniles who offend use thinking errors such as denial, minimization, blaming, and excusing to justify their behavior. Adolescents who perpetrate sex offenses have learned how to do so from being victims of sexual abuse, early exposure to pornography, or both.

Problem Statement

From 1980 to 2010, statistics from the U.S. Office of Juvenile Justice and Delinquency (OJJDP) revealed a 62% increase in the rate of arrests of 10 to 12 year-old males for sexual assault. A rising public awareness of the seriousness and prevalence of this type of offense could be one explanation for such an increase in arrests. As more perpetrators are identified, services are needed to treat the underlying issues which lead to offending.

Ohio

Each state has its own set of laws regarding definitions of sex crimes and how they are interpreted for juvenile cases. In Ohio, where this study was conducted, a juvenile is defined as an unmarried person under the age of 18. A juvenile is charged with delinquency when the offense would be a felony or misdemeanor for an adult, such as a sexual offense.

Figure 1 is based on the most recent data collected from 2003-2013 by the Ohio Incident-Based Reporting System. It suggests that sex crimes perpetrated by juveniles are on the decline in Ohio. One explanation for this decrease could be that since the mid-1980's there has been an emergence of juvenile sex offender (JSO) treatment programs within Ohio.

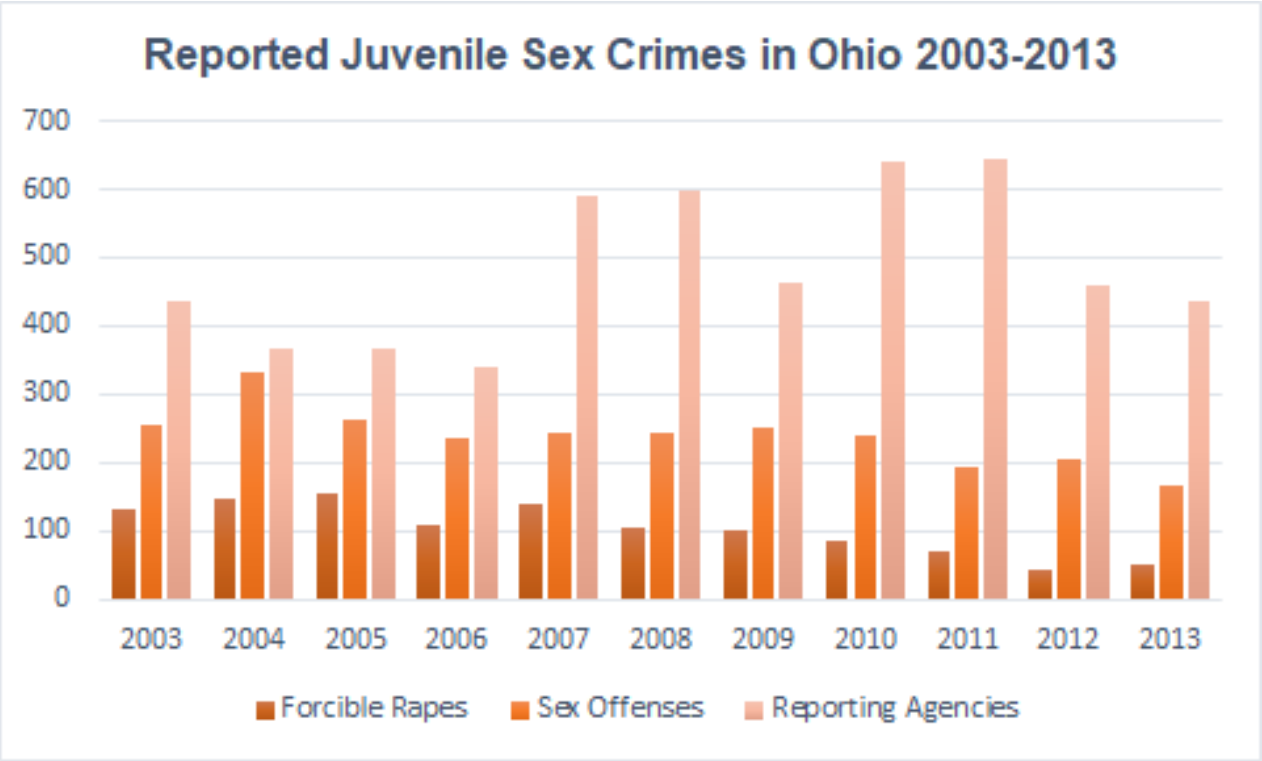

Figure 1. Reported Juvenile Sex Crimes in Ohio from 2003-2013

Psychosocial Characteristics of Juveniles Who Offend

Research to date has shown that there are significant differences between adolescent and adult-perpetrated sex crimes (Shaw, 1999). Although the crimes tend to appear similar on paper, (e.g. fondling, penetration, and exhibitionism), the main causes and motives differ. Juvenile offenses are now viewed as more a product of environment than moral deficiency of the perpetrator.

Margari et al. (2015) compared one group of male juvenile sex offenders with one group of general offenders and one group of non-offenders. The evidence supported findings that juveniles who commit sex offenses are characterized by academic shortcomings, early sexual

activity, and single-parent households. They found that early sexual intercourse was high for both offender groups compared to the non-offender group, and postulated that poor impulse-control was the root motivator for the offense, not deviant sexual aggression as is seen with adult offenders. The evidence suggests that juveniles who commit sexual offenses have more in common with juveniles who commit non-sexual offenses than with adult perpetrators of sexual violence.

Juveniles who commit sex offenses come from diverse backgrounds and all levels of family functioning. Many have experienced high rates of adverse circumstances such as exposure to violence and neglect (Lambie et al., 2002). Some children who have been sexually abused will go on to perpetrate these abuses on others, but the vast majority will not; preteen offenders in particular will overwhelmingly show histories of sexual abuse (Widom & Ames, 1994).

Juveniles do not need to be adjudicated to gain entry into treatment; those who appear at risk to commit offenses (i.e. sexually reactive), may find themselves referred to JSO programs as well. A sexually reactive child is one who is displaying sexual behaviors which are inappropriate for their age. These are usually learned behaviors either from sexual abuse perpetrated by another individual or exposure to pornographic materials.

There is large diversity in type of sexual behaviors and offenses committed by juveniles. This can include touching or grabbing peers, sharing pornographic material, initiating and performing sexual acts on others (including younger children), exhibitionism, and rape The number of offenses can range from one incident to an ongoing pattern of abuse involving one or more victims. Investigators conducted a phenomenological study in 2015 during which they

interviewed four males ages 14-16, and found five common themes underlying the development of their cognitive distortions: absence of a father, emotional dysregulation, poor boundaries at home, unwillingness to accept accountability, and observing sexual materials at an early age (Gerhard-Burnham et al., 2015).

Theories

Social learning theory, developed by Albert Bandura, posits that “psychological functioning is best understood in terms of a continuous reciprocal interaction between behavior and its controlling conditions" (Bandura, 1971, p. 2). When used in practice, the key approach focuses on self-management with the client being the sole owner of internalizing effective coping strategies for overcoming possible influences leading to reoffending (Laws, 1989). Current therapies used with juvenile offenders take this notion to heart, focusing on breaking through cognitive barriers and distorted thinking.

Feminist scholars have characterized sexual violence as having roots in power inequities, especially those found between genders (Ward, 1995). In this view, the male has absolute power over the female, who in turn is physically and emotionally exploited. Also noted is how current systemic structures uphold antiquated patriarchal attitudes which leave survivors of assault, both male and female, feeling blamed and further traumatized for their victimization (Ward, 1995).

Traumagenic dynamics theory, developed by Finkelhor and Browne (1985), postulates that children who experience sexual abuse from a trusted caregiver or adult can have a negative impact on their self-perception, behavior, and even in relationships with peers and other adults. Four mechanisms are thought to be involved in the experience of victimization: traumatic

sexualization, shame and guilt, betrayal, and powerlessness. These feelings can manifest into deeper psychological distress in later adolescence and adulthood.

Current Treatment Trends

There are several key components identified by previous research as integral to the treatment for this population. Cognitive-behavioral techniques, pyschoeducation, and pharmacological interventions are typically used, individually or in some combination (Bourke & Donohue, 1996; Ertl & McNamara, 1997; Hunter & Figueredo, 1999). The key goal of any treatment program is ultimately helping an individual reintegrate successfully into their community by eliminating the risk of reoffending.

Psychoeducation focuses on areas relating to empathy, anger management, thinking errors and cognitive distortions, as well as the abuse cycle (Berenson & Underwood, 2001). Cognitive distortions are defined as the "internal processes, including justifications, perceptions, and judgements used by the sex offender to rationalize … behavior" (Abel, Becker, & Cunningham-Rathner, 1989, p.137). Ultimately, the ability to rationalize a particular behavior provides the impetus towards fulfillment.

One of the greatest tasks for clinicians who work with those who have committed sexual offenses is assessing the risk of reoffending. Scores derived from risk assessments often play a major role in decisions made for placements (home, jail, or residential treatment), decisions about family contact and reunification, and types and length of sentences (Hunter & Figueredo, 1999).

Current research is not sufficient to claim levels of effectiveness of treatment settings. Bremer (1992) reported that adolescents perpetrated zero subsequent offenses after spending at

least 15 months in a residential treatment program. Rasmussen (1999) found that adolescents in a community-based program reported better outcomes, such as lower recidivism rates, over more restrictive settings.

Purpose of the Study

The purpose of this study was to uncover possible predictors of residential treatment completion outcomes of juvenile males who have committed sexual offenses. Treatment providers recognize unsuccessful termination as a serious problem for the communities they serve, and the need for accountability and research into predictive factors is mounting (Kraemer & Salisbury, 1998). No comparable studies were identified in respect to the residential aspect and type of offender population.

Research Questions

The following research questions were developed by the investigator with the agency's needs in mind:

1) Does parental involvement predict treatment outcomes for juveniles who have committed sexual offenses?
2) Does victim type predict treatment outcomes for juveniles who have committed sexual offenses?
3) Does adoption or foster care history predict treatment outcomes for juveniles who have committed sexual offenses?
4) Do risk assessment scores from the Juvenile Sex Offender Assessment Protocol predict treatment outcomes for juveniles who have committed sexual offenses?

Chapter 2: Literature Review

Literature and practice traditions underlying the study variable selection are reviewed in this chapter.

Treatment Outcomes

Eastman (2005) identified intellectual ability, trauma and victimization history, as well as cognitive distortions as showing the strongest correlations to whether a person completes or does not complete treatment. Loeb, Waung, and Sheeran (2015) found that variables such as race, attention deficit disorder with or without hyperactivity (ADD or ADHD) diagnoses, academic performance, and caregiver-child relationships presented significant correlations with successful completion of a juvenile justice diversion program in Detroit, Michigan. Participants in their study had been adjudicated for general offenses, and not necessarily sexual offenses.

When looking at the longitudinal data collected to date, the rates of sexual recidivism patterns into adulthood have been noted overwhelmingly as slim: 4% (Waite et al., 2005), 4% (Vandiver, 2006), and 13% (Tewksbury et al., 2012). Those who reoffend appear to be those more predisposed to violent crime, such as rape (Hanson & Bussiere, 1998; Prentky et al., 1997). A meta-analysis of 82 studies conducted by Hanson and Morton-Bourgon (2005) found general non-sexual recidivism rates to be 13.4%.

Hunter and Figueredo (1999) found in their study that about half of adolescents in a community-based treatment program were unsuccessfully discharged within the first 12 months. Those unsuccessfully discharged from treatment were observed to have higher rates of problematic sexual behaviors and recidivism.

Lynskey and Fergusson (1997) studied a cohort of 1,025 children from birth to 18 years of age. A little over 10% of their sample reported sexual victimization as children. Two factors were found to influence psychological adjustment to the trauma: 1) associations with delinquent peers during adolescent; and 2) the extent of support from a male caregiver in childhood. The presence or absence of these two factors were found to be protective against later adjustment difficulties leading to delinquency.

Victim Type

Ueda (2017) conducted a meta-analysis of 13 studies examining risk factors between those who offended against children and those who offended against peers. The analysis revealed patterns of personality characteristics in both groups. Those who offended against children were more likely to have submissive traits, while those who offended with peers were more likely to have aggressive behavior and conduct problems. From these results, Ueda (2017) suggested submissive-trait offenders would benefit more from individualized cognitive behavioral therapy, while aggressive-trait offenders might benefit more from community-based programs focusing on multi-systemic therapy.

J-SOAP II

Hittle House uses the Juvenile Sex Offender Assessment Protocol (J-SOAP) and more recently, the J-SOAP-II, with residents ages 12 and up as part of the intake process and also intermittently throughout treatment to measure progress. Data from the J-SOAP, an evaluator-reported intake assessment, is scored in three ways: static, dynamic, and combined static and dynamic. The original J-SOAP was constructed in 1994 by Prentky and Righthand as a response to a growing demand for instruments which could assess risk of recidivism for adolescents who

have committed sex offenses. Interrater reliability and internal consistency were tested for the J-SOAP, with findings ranging from good to excellent (Righthand, Prentky, Knight, Carpenter, Hecker, & Nangle, 2005).

The J-SOAP II is a 26-item checklist designed to assist in the systematic review of the risk factors identified in the professional literature as being associated with adolescent sexual and criminal reoffending. There are four scales in the assessment: 1) sexual drive and sexual preoccupation, 2) impulsive, antisocial behavior, 3) clinical intervention, and 4) community stability. When assessing for risk and protective factors, clinicians use an ecological perspective and gauge past and present static and dynamic factors to determine future risk.

Family Involvement

Caregiver engagement is generally thought to be a crucial component of treatment success, however, low levels of engagement are consistently of concern to service providers (Worley, Church, & Clemmons, 2011). There are many ways in which a family can be involved in a Hittle House resident's life during treatment. Residents are permitted phone calls, written correspondence, on-site visits, and off-site visits. This study looks specifically at caretaker involvement, but there are many facets to consider when taking siblings and extended family into account. Although minors are not permitted inside the facility, residents' siblings and other younger family members can write letters and participate in phone calls.

Adoption/Foster Care History

Huang, Ryan, and Rhoden (2016) hypothesized that juveniles moving into a neighborhood with high concentrations of disadvantage and residential instability correlated with higher risk for juvenile delinquency. Findings indicated that male foster youth, and all foster

youth who experienced neglect, were more susceptible to juvenile delinquency. A federal study reported that three-quarters of Connecticut juveniles in custody were at one time in the foster care system, while another study revealed that 80% of those incarcerated in Illinois had also been in foster care (Azar, 1995).

Treatment interventions at Hittle House.

The clinicians at Hittle House use cognitive behavioral therapy in conjunction with the Pathways curriculum which remediates the boys' psychological deficiencies and corrects thinking errors. Specifically, the treatment team employs the Interpersonal Cognitive Problem Solving model, developed by Spivak, Platt, and Shure (1976). Testing is used at intake to assess risk, resiliency, and self-awareness, including but not limited to: the Affinity Measure of Sexual Interest, the Problem Oriented Screening Instrument for Teenagers, the STAXI-2 C/A (which screens for anger traits), the Estimate of Risk of Adolescent Sexual Offense Recidivism, and the Juvenile Sex Offender Assessment Protocol II (Manno, 2008).

There are seven groups at the agency in which all of the boys must participate. The groups are lead by staff which are trained in mental health by the clinicians. The groups are called Healthy Living, Social Skills, Anger Management, Tolerance and Empathy, Coping Skills, Offenders Group, and Survivors Group. The last two are facilitated by clinical staff who are licensed social workers (Hittle & Bush, 2007).

In addition to the groups, the boys also have two to three individualized therapy sessions per week. Education is provided on-site by Lumin Academy which also provides physical education. The boys get at least one hour of physical education per day and three hours of school. Once per month the agency hosts a parents' night. The parents or guardians are allowed

to spend one hour with their child and eat dinner together. After dinner, the parents participate in group therapy where they can share their experiences and learn from the experiences of others in the group. At the close of the group they are given feedback forms which they can fill out with comments and concerns.

Relapse prevention is addressed as the client nears treatment completion. The caregivers of the residents are invited to participate in family therapy sessions, and new goals are created which address the needs for every member of the household. A safety plan is created by the resident which identifies risky situations and strategies to overcome them. At this point in treatment, the residents have a good working knowledge of coping strategies, thinking errors, and risks of reoffense.

Impact on Society

Public safety is often cited as the largest concern among those who work with people who have committed any type of offenses, especially when potential victims are readily available. The next concern is matching limited resources to the needs of individuals who have offended. Communities can usually provide several inpatient and outpatient treatment options, with incarceration being the most extreme.

Studies have shown the significant costs which sexual assault has on public welfare. Post, Mezey, Maxwell, and Wibert (2002) conducted a study in Michigan which revealed upwards of $7 billion in one year alone, accounting for costs relating to police, advocates, and health and medical services, as well as decreased quality and engagement with life activities. Dolan, Loomes, Peasgood, and Tsuchiya (2005), also found similar evidence of the high cost of intangible effects to quality of life which result in the disengagement of routine activities.

The Present Study

I conducted a quantitative, administrative data study of the adolescents admitted to a long-term residential JSO treatment program. Clients who completed the treatment (i.e., the "successful completers") were compared with those who did not complete treatment (i.e., the "unsuccessful completers") using a de-identified data set from the program's case records. The groups were compared on the previously described variables: victim type, parent involvement, adoption/foster care history, and J-SOAP II scores.

Chapter 3: Methodology

This study looked at the case records of 170 juvenile males who had participated in and had been discharged from a residential treatment program facilitated by Hittle House between 2009 and 2017. This number represents the entire population of participants who have been discharged from this facility since its inception in 2009. The inclusion criteria in this study were assumed to have been met by acceptance into the program. The participants were be divided into two groups for analysis: successful completion and unsuccessful completion.

Data Collection Procedures

Data were collected solely through case review at Hittle House. Staff at all levels in the facility collected information about the clients onto paper documents during the course of treatment. Data were extracted by the investigator onto paper forms pre-formatted for use with Remark Optical Mark Recognition Software and then transferred into SPSS v. 24 for analysis (see Appendix A). Client records were each assigned a random number identifier which was kept on a hard-copy form stored within the agency in a locked filing cabinet. The institutional review

board at the Ohio State University reviewed the study protocol and approved it as an expedited study.

Participants

This study looked at a population of adolescent males, aged 12-18, admitted to a residential treatment program for juvenile males who exhibit sexually reactive behavior. The majority of those admitted had sexually offended before entry, and had been discharged from the program between August 15, 2008, and December 24, 2017. The sample included both adjudicated and non-adjudicated youth.

Out of 170 total discharges for the program, 94 were included in this study. Those who had incomplete or missing data were excluded. Of 94 participants, 52.1% (n=49) successfully graduated from the program, whereas 47.9% (n=45) failed to complete treatment. Reasons for unsuccessful discharge from the treatment program included resistance to engaging with the therapeutic process, absconding from the agency in such a manner as to be discharged from care, aging out, self-harm including attempted suicide, being unfit for the program, and transfer.

The informed consent process was waived for this study. The 1974 Federal Privacy Act (PL 93-579) stipulates clients need not be informed about the sharing of their personal records when the records have been de-identified.

Setting

The setting for this study was a 30-bed residential treatment rehabilitation program for adolescent boys aged 9 to 17. The program does not have a predetermined length of stay, but a typical stay is approximately one year, during which time psychiatric, educational, medical, and therapeutic services are provided. Clients of this program are referred through many avenues

including county courts, self-referral through their families, other treatment programs, and social workers.

To be admitted into the program an adolescent must exhibit general problematic sexual behaviors, and most will arrive having previously victimized someone (Hittle House, 2017). The boys come from a diverse mix of racial and socio-economic backgrounds and are referred by caseworkers and juvenile courts throughout Ohio. The therapeutic goals of the residential treatment programming include promoting accountability, increasing interpersonal relationship skills, and providing consistency and nurturing from supportive adults (Hittle House, 2017)

Variables

One dependent variable with two categories, successful and unsuccessful completion, was examined against four independent variables. One risk assessment variable (J-SOAP), one family involvement variable, and two background variables (adoption/foster care history and type of victim) were examined.

J-SOAP II. The J-SOAP II is a scored assessment completed by a clinician. Percentage scores which measure likelihood of risk are derived from examining static and dynamic variables. The "total" score is a combined score from all items on the 26-item lists. There are two static scales which measure historical data, with a score range of 0-16 for each: sexual drive and preoccupation, and impulsive-antisocial behavior. The 3rd scale measures the impact of clinical intervention, if any, and is scored from 0-14. The 4th scale measures community stability and adjustment from 0-10. After scoring, a percentage of risk is determined. This item was scored on the Remark form as a percentage, 0-100, as it is in other contexts. A higher score indicates a greater level of risk.

F**amily involvement.** Parental involvement was measured by the rate of visitation and phone calls. The scores placed the parent or guardian into one of three categories: highly involved >66%, somewhat involved >33%, and not involved <33%. Involvement was measured by incremental brackets of 33%. Factors included what percentage of parent nights they attended and how often they visited the participant. Visitation was measured by month, i.e. if the participant was at the agency for 12 months and the parent or guardian visited once per month, then the involvement score would be 100%. If they visited once every other month, the score would be 50%. The two scores were then averaged for a final percentage of involvement, which placed them into one of the three brackets.

Adoption/Foster care history. Adoption and/or foster care history was measured as "yes" or "no" dichotomous categorical variable. This variable specified whether or not there were any incidences, not frequency or duration. Cases in which the juvenile switched custody into a familial arrangement in a secondary home were included in the "yes" category.

Victim type. Victim type was assessed using four categories: 1) sibling, 2) friend, 3) sibling and friend, and 4) other. Non-sibling familial victims who were not residing in the home at the time of the offense were included in the "friend" category, whereas non-sibling familial victims residing with the offending juvenile were included in the "sibling" category. The "friend" category included victims who were known in any context to the perpetrator prior to the offense. The "other" category included any victim not aforementioned.

Chapter 4: Results

Data Analysis

Data from 94 case files were used during the data analysis process. Variables were coded onto forms formatted for use with Remark. All analyses were performed using SPSS v.24. Descriptive statistics can be found in Table 1.

Table 1.

Description of Variable Frequencies

	Frequency	Percent	Valid Percent
Victim Type			
Sibling	50	53.2	53.2
Friend	39	41.5	41.5
Sibling & Friend	4	4.3	4.3
Other	1	1.1	1.1
Adoption/Foster Care History			
Yes	45	47.9	47.9
No	49	52.1	52.1
Parental Involvement			
Low (<33%)	24	25.5	25.5
Somewhat (33-65%)	25	26.6	26.6
High (66%+)	45	47.9	47.9
Completion Outcome			
Successful	49	52.1	52.1
Unsuccessful	45	47.9	47.9

The J-SOAP-II scores ranged from 20-80. The median was 49, and the mode was 45. The scores had a standard deviation of 13.6.

Treatment Completion

The outcome measure was successful or unsuccessful completion of treatment, which the agency determined based on completion of treatment goals (e.g., honest participation in group and individual therapy, measured and observed progress on goal objectives). I used bivariate analysis to examine the differences between clients who successfully completed treatment (n=49) and clients who were unsuccessful (n=45) on the four independent variables. The variables examined for association with completion of treatment included level of family involvement, initial J-SOAP scores upon entry to the program, adoption/foster care history, and victim type.

Were J-SOAP II scores related to treatment completion?

Logistic regression analysis for the J-SOAP scores predicted successful program completion versus other outcomes ($p<.001$) 67% of the time, where lower scores were associated with successful completion. The range of scores fell from 20%-80%.

Was family involvement related to treatment completion?

I looked at the objective data drawn from case files about family involvement. Chi-square analysis was significant for successful outcome by parent involvement ($\chi 2(2)=12.615a$, $p<.05$),but not by victim type or adoption history; Parent involvement was not significantly related to victim type but was related to adoption/foster care history ($\chi 2(2)=7.806a$, $p<.05$)Analysis of variance showed parental involvement was lowest when J-SOAP problem scores were high ($F(2,93)=4.158$, $p<.05$).

Was adoption or foster care history related to treatment completion?

Chi-square analysis was performed to determine if there was a relation between adoption/foster care history and program completion. It was determined that this was not a predictor of treatment outcome ($p>.05$).

Was victim type related to treatment completion?

Chi-square analysis showed that victim type was not a predictor of treatment outcome ($p>.05$). Of those who successfully completed treatment, 27 offended against a sibling, 18 against a friend, 1 against "other", and 3 offended against both a sibling and a friend. Of those who did not successfully complete treatment, 23 offended against a sibling, 21 against a friend, 0 against "other", and 1 offended against both a sibling and a friend. One-way ANOVA analysis also showed victim type was unrelated to J-SOAP scores ($p=.522$).

Chapter 5: Discussion

Summary of Results

This study sought to reveal possible predictors of successful program completion. I found that lower J-SOAP risk scores were associated with successful completion. This is not a surprising result, as this risk score measures not only dynamic variables, but also static variables which cannot be changed or altered, such as history of abuse. High parental involvement was also found to be a significant predictor of program success.

A history of involvement with foster care or adoption history were not found to be predictive of completion outcome. As some of the participants in this study were placed in the foster care system due to their own delinquency, this is not a surprising result. Victim type was also not predictive of completion outcome.

Implications

The results of this study may not be generalized to the juvenile offender population at-large, but can be used to inform early intervention practices within Hittle House and similar programs. High parental involvement was found to be a significant predictor of program success, which confirms what current literature has shown to be true for general juvenile offenders. Many caregivers have circumstantial barriers to participating, such as lack of transportation or cost of travel. Yoder and Brown (2015) explored caregiver barriers to engagement and found that parents reported overwhelming stress, lack of preparedness, and lack of informational and tangible resources as obstructing engagement with their child's treatment. Knowing the importance of parental involvement could lead to needs assessments of caregivers as a first step to deconstruct these barriers. It was reassuring to note that parental involvement was not related to victim type or adoption/foster care history.

Although this study used the initial J-SOAP II scores from intake, further research could investigate subsequent assessment as it relates to goal achievement and program completion. The four separate dynamic and static categories which are scored could be parceled out in further analysis. To date, research regarding predictors of treatment outcomes remains minimal, and what exists examines small samples within one or several agencies.

Limitations of the Present Study

There were limitations that impacted the scope and depth of this study, including population size and sampling method. Due to the limited number of potential participants, convenience sampling was used. The sample was largely homogeneous when factoring in race,

ethnicity, and gender. Some of the participants presented with impaired cognitive abilities, trauma histories, and mental illness, but these factors were not taken into account in this study.

Additionally, the J-SOAP II is a therapist-reported assessment based on observation. Observation can be subject to bias, exaggeration, or even lack of relevant knowledge which would inform the observer. Demographics relating to race and age were also not collected for this study. Data that were collected for this study were analyzed for correlation, and as such, causal inferences cannot be drawn. As this was merely meant to be an exploratory study, it may be possible to use these finding as groundwork for future research.

Recommendations for Future Research and Conclusion

A longitudinal study could examine the whole course of an adolescent's treatment through quantitative and qualitative measures. Clinicians and other staff at Hittle House already collect copious amounts of data, and if streamlined for use in a longitudinal study, it could potentially provide more rigorous means of exploring possible predictors of success.

In future studies, it could be beneficial to examine the residents' perceptions of their families' involvement, which possibly would provide a more valid means of measuring this variable. Attachment within relationships looks different from family to family, and so frequency of caregiver visits does not provide a whole picture. There are many other variables which could be examined in future studies, such as length of stay, scores from other assessment instruments, clients' perceptions, cognitive functioning, trauma history, sexual abuse history, and parental factors.

Although not all, and certainly not most, juveniles who commit sexual offenses will go on to reoffend sexually, treatment is still our most salient means of defense against future

uncertainty. Given the staggering number of sexually-offending adult inmates who committed first offenses as juveniles, early and successful treatment completion is especially important.

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Appendix A: Data Transfer Form Formatted for Remark

1. Random Id Code	hundreds	tens	ones	_____
	O 0	O 0	O 0	
	O 1	O 1	O 1	
	O 2	O 2	O 2	
	O 3	O 3	O 3	
	O 4	O 4	O 4	
	O 5	O 5	O 5	
	O 6	O 6	O 6	
	O 7	O 7	O 7	
	O 8	O 8	O 8	
	O 9	O 9	O 9	

	O	O
2. Completion Outcome	Successful	Other

3. J-SOAP (percentage)	hundreds	tens	ones
	O 0	O 0	O 0
	O 1	O 1	O 1
		O 2	O 2
		O 3	O 3
		O 4	O 4
		O 5	O 5
		O 6	O 6
		O 7	O 7
		O 8	O 8
		O 9	O 9

	O	O	O	O
4. Victim type	sibling	friend	stranger	other

	O	O
5. Adoption/foster care history	yes	no

	O	O	O
6. Parental involvement:	low (<33%)	somewhat (33%-65%)	high (>66%)

Data entry/coding concerns:

Data entered into SPSS on: _____ (date)